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APPLE HOME HEALTHCARE

Medicare Equity in the Interim Payment System
Emerges As Crucial Issue for Home Health Recipients
Senate Special Committee on Aging
Dirksen Senate Office Building
Room 628
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INTRODUCTION

I am David Martin, Administrator and co-owner of Apple Home Healthcare Inc., a Joint Commission Accredited home health agency and, also, a co-owner of Metro Preferred Health Care, Inc. Both agencies deliver home health service in the metropolitan New Orleans area. Apple is a member of the Homecare Alliance of the South, Inc. (HAS) which is a not-for-profit organization representing over 30 independently owned agencies located throughout Louisiana. I have consulted with HAS' Director, Steve Freeman, in drafting testimony that is reflective of my problems as well as problems of other members of the alliance.

MESSAGE: INEQUITIES IN THE CURRENT INTERIM PAYMENT SYSTEM

While there are many important issues that presently face our industry such as surety bond requirements and the exclusion of venipuncture as a covered home health service I will focus only on one... the Interim Payment System (IPS). The message that I would like to leave with you today is that reform of the current IPS can help bring the desired cost savings to the Medicare program while still maintaining access to care and quality of care for Medicare beneficiaries. I realize that problems of fraud and abuse that are occurring nationally have been magnified in Louisiana because, for years, there were virtually no barriers to entry for the industry in our state. Previous unrestricted entry into the industry in Louisiana has produced an over saturated market of more than 500 home health agencies. In order for many of these agencies to maintain viability there has been rampant overutilization of services. While acknowledging that reform is necessary and welcomed by honest providers, one must be careful to not adversely affect the legitimate providers and their patients.

FAIRNESS AND EQUITY IN REIMBURSEMENT

Before addressing the issues concerning unequal reimbursement for home health agencies I would like to segment IPS reimbursement into two components. The first is the Per Beneficiary Limit (PBL) calculation that is performed on agencies that have submitted a twelve month cost report by the close of Federal fiscal year 1994. Agencies that meet this criteria will have their PBL set at the blended rate of 75% of their specific agency cost and 25% of the average agency cost in their respective census region. These agencies will be referred to as "old" providers. The second component is the PBL calculation for agencies that do not have a twelve month cost report as of the end of Federal fiscal year 1994. These agencies are slated to receive the national average PBL with no blend for their agency specific cost or their census region cost. These agencies will be referred to as "new" providers.

The current IPS is plagued with inequity in reimbursement by having different PBLs for agencies. This problem exists not only for "old" versus "new" agencies but also for competing "old" agencies that had completely different cost structures in the 94 base year,

Presently, efficient "old" providers or a "new" provider using the estimated national PBL of $4,000 is forced to compete with the inefficient "old" provider who may have a PBL of more than 2 to 3 times the national average. These agencies are serving similar patients and are drawing from the same wage and labor markets. It is apparent that the high cost provider has a distinct competitive advantage over the lower cost provider.

In February of this year I lost three office employees and five caregivers to a competing agency. Upon exit interviews with these staff members it was discovered that my competitor touted its PBL of $13,000 as a recruiting tool. These employees were told that no matter what happened in the industry their agency would survive because of the high PBL. These same employees were offered salaries ranging from 15 - 30% more than what they were currently earning because this agency had such a high PBL. How can efficient providers with a PBL at or near the national average recruit and retain quality staff?

The inequities in the PBLs affect more than just the low cost providers. They affect the beneficiaries as well. While reaffirming that the market could sustain some level of shakeout without interfering with patient care in Louisiana, the effect of IPS would jeopardize the viability of substantially all of the "new" providers. In Louisiana this would account for 67% of home health agencies. This drastic reduction of providers would create a patient access to care problem as there would not be enough agencies to provide care to all patients that qualified. Eventually, these patients would end up in the highest cost institutions for care such as hospitals and nursing homes. Any savings realized by the decrease in the number of home health visits would be more than offset by the added expense of having these patients cared for in traditional settings.

Another unintended result of having different PBLs for agencies in the same market is that after the shakeout is over the only agencies remaining will be the highest cost providers. These new mega-agencies would flourish through attrition and would help to erode and negate any savings that had been hoped for in the implementation of IPS.

ONE RATE PER REGION: EQUATING PAYMENTS WITH POPULATIONS

The proposed concept of using the national average PBL for the entire country is flawed. Forcing agencies to use the national average in their respective region will create undue hardships on agencies and patients in some areas while promoting excess utilization and reimbursements in others. Using the national average fails to take into account regional abberrances which result in different costs per beneficiary across the country. Factors that need to be considered are availability of community resources to patients, state Medicaid programs and requirements, poverty, education level, and community health issues. When considering these facts it makes more sense to use regional limits so as to better reflect the patients needs in that area.

Inaccurate reflection of patient demographics is not the only problem with applying the national average across the country. It also has a negative effect on beneficiaries that have the most intense and complex cases. These patients are our sickest, most frail citizens. These costly patients will be denied access to home care services as agencies will be at a financial disadvantage if they accept the case. The agencies that do admit these tough cases will be forced to "cut corners" in their delivery of care in an effort to control costs. It is inevitable that the quality of care for these patients will be diminished.

In an effort to keep case cost close to the national average, John Fontana, a member of HAS and the owner of Audubon Home Health, was investigated last Tuesday by the Department of Health and Hospitals in response to a patient complaining of reduction of utilization. The surveyor found that

Audubon's actions had been appropriate and there was no further action taken by the state. This is one isolated instance of a much larger problem of patients' level of care being adversely affected by the national PBL.

At Apple we have already had to make tough choices before admitting patients. We were recently faced with a situation which involved a wound care referral who needed sterile dressing changes twice a day. We knew that the cost of care for this patient could easily run in excess of $12,000. In light of being saddled with the national limit we could not accept the case. This is not how home care is supposed to work. Where are these patients supposed to go to receive care under the IPS system... Medicaid, Hospitals, Nursing homes?

PER BENEFICIARY EFFECTIVE, DATE: OPERATING IN THE DARK

Perhaps one of the most bizarre twists of the IPS is that the effective date of the system was October 1, 1997 but the PBL is still unpublished. Even though the limit is due out tomorrow, many agencies nation wide have been operating without knowing what their reimbursement level will be. This has created a huge operational dilemma. What level of care am I able to provide for my patients and still be assured that I won't be faced with an overpayment at the year's end? How do I compete with "old" providers who already know what their limit is?

Lauren Glonek, another member of HAS and the owner of Excelcare Home Health, has already been forced to take drastic action on this issue. In fear of not knowing where her agency needed to be cost wise, she was forced to reduce caregivers rates by an average of 12%. She also reduced all office staff salaries including her own by 10%. Even though Excel's own per beneficiary cost is lower than the PBL in its census region, layoffs were necessary to avoid a potential overpayment at year end if the national PBL were applied. Good, diligent, high performing employees were laid off in order to help bring the overhead more in line with the worst case scenario of the national PBL. This same situation is being played out by low cost providers across the nation. The issue of operating blind has played squarely into the hands of the higher cost "old" providers because of the simple fact that they have more leeway and need not be concerned about the PBL.

As in previous examples, what affects the home health agency also affects the patients of that agency. Besides controlling costs internally to combat operating in the unknown, agencies are also being forced to reduce services to beneficiaries. Again, reduction in services is being relied upon to help assure that the provider will not be in an overpayment situation once the final limits are published. This too is playing into the hands of the higher cost providers as they can not only maintain the current level of care but can, in many instances, increase the number of visits the patient is receiving. The patients on service at the low cost or "new" agencies will end up in one of a finite number of places... the high cost or "old" provider or back into a traditional institution.

SOLUTIONS

- Implement the same PBL for all agencies in a given region regardless of agency specific base year cost or "new" or "old" status. This will allow all agencies to compete on a level playing field and would achieve HCFA's goal of being left with the most efficient providers.

- Use the regional PBL instead of the national to allow for differences in patient demographics and regional aberrances.

- Postpone the effective date for IPS until October 1999 in order to allow agencies time for a proper

transition. Have the same rate for agencies in a given region take effect at the same time.

CONCLUSION

I am appreciative of having the opportunity to speak to this important topic. Seldom does an issue present itself which has outstanding potential to improve the delivery of health care to Medicare seniors while at the same time hold dire circumstances for an industry and its patients. The deciding criteria for success or failure lies in the minutia of legislation, regulation, and implementation. I encourage your diligence in fashioning a solution that is fair and equitable to all stakeholders.